STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING _____ B. WING _____	01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SUMMIT CITY	2940 N CLINTON ST FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Visit was for a Recertification and State Licensure Survey. Survey dates: January 24, 25, 26, & 27, 2011 Facility number: 000079 Provider number: 155159 AIM number: 100266160 Survey team: Sue Brooker RD TC Rick Blain RN Julie Wagoner RN Christine Fodrea, RN [January 25, 2011] Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 10 Medicaid: 46 Other: 17 Total: 73 Sample: 15 Supplemental sample: 8 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 2/3/11 by Jennie Bartelt, RN.	F 000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 26, 2011 **F 241 Dignity and Respect of Individuality** It is the intent of this facility to ensure that residents receive adequate supervision, cues and assistance during dining services to ensure a dignified dining experience. **Corrective Action for affected residents**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

add req. 2/23/11 BM

app 3/9/11 BM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/17/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure 2 of 5 residents reviewed for dining needs received adequate supervision, cues, and assistance to ensure a dignified dining experience (Residents #3 and #27) in a total sample of 15. Finding includes: 1. On 01/24/11 at 11:53 A.M., the meal trays were observed to be delivered on a cart to the Advanced Alzheimer's Unit (AAU) dining room. The meal tray for Resident #3 was delivered to her and set up for her and she was instructed to eat. The resident was noted to eat with her fingers and pick up her dessert plate, on which she had picked at a piece of cake, and lick the plate. CNA #5, noticed Resident #3 licking her dessert plate and during interview at this time indicated, "Poor (resident's name), she really likes her sweets." The CNA did not redirect the resident from licking her plate or from eating with her fingers. At one point, Resident #3 stuck her fingers in her mashed potatoes. The resident was noted to have icing, juice, and cake crumbs all over her chin and shirt. On 01/25/11 at 12:06 P.M., Resident #3's tray was delivered to her. The staff put butter on her sweet potato and left the resident to feed herself. The resident was noted to eat her cherry cobbler dessert directly out of the bowl without using silverware. The dessert dribbled down the	F 241	Resident #3 and Resident # 27 are being cued and supervised throughout meal services. **Identification and corrective action taken for other residents potentially affected** 100% review of all other residents on AACU requiring supervision and/or cueing completed with no other concerns on February 10, 2011. **Measures/Systemic changes to ensure that the deficient practice does not recur** All nursing staff on 2nd floor inserviced on supervision and cueing of residents during mealtimes completed by Feb 18, 2011. Daily audits will be completed by Administrator/designee and will be reviewed during morning meeting to ensure supervision and cueing occurred. **Monitoring of corrective action to ensure the practice will not recur- QA program in place**	

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F 241	Continued From page 2 resident's chin, clothes, and was noted all over her fingers. She did not receive any cues to use her silverware. At one point she stabbed a piece of bread with her fork and attempted to take a bite, but the bread rotated on the fork, and she did not get a bite of food. The clinical record for Resident #3 was reviewed on 01/26/11 at 9:45 A.M. The resident's most recent Minimum Data Set (MDS) assessment for Resident #3, completed on 01/13/11, indicated the resident required moderate staff assistance of 1 for eating needs, and extensive staff assistance for hygiene needs. Review of the current health care plan regarding activities of daily living included the intervention to "Set up supplies, promote dignity" and "Give verbal and visual cues as needed." Resident #3 was observed on 01/25/11 at 2:00 P.M. wandering throughout the AAU unit with red cobbler still on her chin and food stains on her clothes. Staff did not attempt to clean the resident until 2:35 P.M. 2. On 01/25/11 at 12:21 P.M., Resident #27 was observed sitting at a table without any staff cues or assistance. The resident's left hand was noted to be lying in his pureed meat and gravy. The resident was attempting to feed himself with his right hand but was noted to have dribbled most of his dessert and vegetable down his chin. The clinical record for Resident #27 was reviewed on 1/26/11 at 9:00 A.M. The most recent minimum data set (MDS) assessment for Resident #27, completed on 12/23/10, indicated the resident required	F 241	Daily monitoring audits will be completed and any issues identified will be addressed immediately. Any issues identified will be discussed in the quarterly Quality Assurance meeting. Administrator/Designee responsible for ongoing compliance. **Completion Date: February 26, 2011** **F248 Activities Meet Interests/Needs of each Resident** It is the intent of this facility to provide an ongoing activity program on the Advanced Alzheimer's Unit. **Corrective Action for Affected Residents** Activity Programming for all residents residing on the AACU was evaluated on February 10, 2011 and will be implemented to meet the needs of the residents to include social, physical, spiritual and sensory stimulation. Personal care as defined in ISDH Alzheimer's Dementia seminar's Activity book has also been added to the Activity schedule.	

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F 241	Continued From page 3 supervision for eating needs. Review of the current health care plan regarding eating needs indicated the resident was to be assisted. 3.1-3(t)	F 241	**Identification and corrective action taken for other residents potentially affected** No other residents were identified. **Measures/Systemic changes to ensure that the deficient practice does not recur** All staffing inservices have been completed Feb 18, 2011. Staffing ratios that were 1 staff member to 6 residents have been evaluated. Alzhemier's Care Unit Director/designee will monitor activity schedule to ensure compliance 3 times a week. **Monitoring of corrective action to ensure the practice will not recur- QA program in place** Audits will be completed and discussed weekly during Patients At Risk meeting. Any issues identified will be immediately addressed with staff. Findings will be discussed in quarterly QA meetings.	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide an ongoing activities program on the Advanced Alzheimer's Unit. This potentially affected 12 of 12 residents residing on the Advanced Alzheimer's Unit and 1 resident who dined in the Advanced Alzheimer's Unit. (Residents #1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 27) Findings include: The activities calender for January 2011 for the Advanced Alzheimer's unit (AAU) indicated all days of January 2011 had the following activities scheduled: 10:00 A.M. - Range of Motion and Snacks, 11:00 A.M. - Soft Music and Readings, 1:15 P.M. - Sensory Time, and 2:00 P.M. - Snacks and Social Time. The following activities assessments/progress notes and care plans regarding activities were reviewed on 1/27/11 at 2:45 p.m. and indicated	F 248		

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F 248	Continued From page 4 for the following residents: Resident #1: Activities Progress notes, completed 01/03/11 - No individual activities preferences were noted on the form and the note indicated the resident was daily involved in activities on the AAU unite with music, sensory groups, wheeling on the unit with staff, and going off the unit to music programs. The note indicated the resident did not require 1:1 programming. The current health care plan regarding activities indicated the resident was to attend and participate for short periods of time the programming on the AAU dementia unit. Interventions included greeting the resident, inviting him to groups, assisting him with transportation to groups, and the resident was documented to enjoy patriotic and oldies music. Resident #2: Activities Progress notes, completed on 08/12/10 and 11/09/10 indicated the resident enjoyed music and dancing, walking on the unit with his wife, and watching television passively. The assessment indicated the resident did not require 1:1 programming and would usually only stay briefly in activities. The health care plan regarding activities for Resident #2 indicated he needed daily programming with cueing and assistance. Interventions included greeting the resident daily, giving cueing and assistance as needed during activities, assisting to activities, encouraging family involvement, and the resident was documented to enjoy music, readings, exercise, games, sorting, walking and spiritual activities. Resident #3: Activities Progress Notes and Assessment, completed on 12/27/10 did not indicate any individualized activity preferences.	F 248	Alzheimer's Care Unit Director/designee will be responsible to ongoing compliance. **Completion Date: February 26, 2011**	

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The progress note indicated the resident was passively involved in activities on the AAU unit, would not stay in activities for long periods of time but would allow hand massages and would play ball for short periods of time. The note also indicated the resident enjoyed walking/wandering the hall of the unit, handling dolls and stuffed animals, and handling tactile objects. The note indicated the resident did not need 1:1 programs. The current health care plan regarding activities indicated the resident needed daily programming on the AAU with cueing and assistance. The goal was for the resident to attend daily programming on unit daily for short periods of time. Interventions for the plan included greeting the resident daily, encouraging the resident to sit for groups, cueing the resident, the resident was to be included in activities requiring singing, socializing, and tactile stimulus, walking with the resident, encouraging the resident to express "love" by giving hugs, and the resident was documented to enjoy handling soft fabrics, baby dolls, and stuffed animals.

Resident #5: Activities Progress Notes and Assessment, completed on 12/30/10, did not indicate any activities preferences. The progress note indicated the resident preferred to be in a recliner, enjoyed music and sensory activities involving touch. The note indicated the resident did not require 1:1 programs. The current health care plan for Resident #5 regarding activities indicated the resident had a need for diversional activities related to cognitive status and would be involved in programming on the unit. Interventions to the plan included greeting the resident daily, assisting her with Activities of Daily Living and recreational groups, allowing her to walk as desired, encouraging the resident's

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husband to involve her in activities, and to include the resident in sorting, matching, music, exercise, small group, and recreational activities.

Resident #6: Activities Progress Notes and Assessment, completed on 01/03/11, did not indicate any activity preferences. The progress notes indicated the resident handled and rocked dolls, sat in the family den with peers, enjoyed aromatherapy and massage activities, attended music programs off the unit and passively participated in activities on the unit. The note indicated the resident did not require 1:1 programs. The current health care plan regarding activities for Resident #6 indicated the resident needed recreational activities with invitations and cueing both on and off the unit. Interventions included greeting the resident daily, inviting her to group activities, cueing and assisting her to and from activities, and the resident was documented as enjoying music, games, crafts, parties, and spiritual groups.

Resident #7: Activities Progress Notes and Assessment, completed on 01/18/11, indicated there were no individual activity preferences marked on the form. The progress note indicated the resident attended group activities both on and off the unit, but spent most of her time off of the AAU unit. The note indicated the resident did not require 1:1 programs. The current health care plan regarding activities for Resident #7 indicated the resident would attend and participate daily in programming on the unit and on other units. Interventions included reminding the resident of activities, assisting and cueing the resident as needed, and inviting her to activities of interest on other units, the resident was documented as enjoying music, social hours, theme parties,

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F 248	Continued From page 7 games and spiritual groups. Resident #8: Activities Progress Notes and Assessment, completed on 01/10/11, indicated there were no individualized activity preferences marked. The progress note indicated the resident participated passively in activities due to her short attention span. The note indicated the resident did participate in a ball bounce, liked to handle stuffed animals and other tactile items. The note indicated the resident did not require 1:1 programs. The current health care plan regarding activities for Resident #8 indicated the resident was to engage in daily programs on the AAU unit or short periods of time. Interventions to the plan included greeting the resident daily, giving the resident simple directions, encouraging the resident to attend programming on the unit, and the resident was documented to enjoy walking in the halls and handling baby dolls. Resident #9: Activities Progress notes, completed on 11/15/10, indicated the resident enjoyed music and sensory stimulation activities such as touching soft fabrics and stuffed animals. The note indicated the resident wandered in the hall daily. The current health care plan regarding activities included a goal for the resident to attend daily group sensory activities with interventions to socialize with and greet the resident daily, encourage and invite to daily programming on the unit, cue the resident to activities, and the resident was documented to enjoy handling tactile items and soft fabrics. Resident #10: Activities Progress note, completed on 11/10/10, indicated the resident attended group activities involving music or food. The note also indicated the resident enjoyed	F 248		

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sitting by the birds or spending time in the "chapel." The resident was to be encourage to continue attending group activities. The current health care plan regarding activities for Resident #10 indicated the resident required daily programming on the unit. Interventions included greeting the resident daily, sitting the resident near the speaker due to hearing needs, inviting the resident to music programs, encouraging the resident to singing and sing along type activities. The resident was documented to enjoy music programs, food events, and helping others.

Resident #11: Activities Progress Notes and Assessment, completed on 01/04/11, did not indicate any individualized activity preferences. The progress note indicated the resident's participation in activities on the unit would be observed until the next review. The resident was noted to wander in and out of activities and had a history of passive participation in activities. The current health care plan regarding activities for Resident #11 indicated the resident had a need to be involved daily with programming on the unit. Interventions included greeting the resident daily, encouraging participation and interaction, reminiscing conversations, stacking and sorting activities, busy box with gadgets and locks, and conversing about the army and working.

Resident #12: Activities Progress Notes and Assessment, completed on 12/14/10, did not indicate any individualized activity preferences. The progress note indicated the resident participated passively in daily activities on the unit but only stayed for short periods of time due to a short attention span. The note indicated the resident preferred to walk in the hall during most of the day. The note indicated the resident did

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F 248	Continued From page 9 not require 1:1 programming. The health care plan regarding activities, current as of 11/18/10, indicated the resident was to be greeted often, encourage with diversional activities, allowed to explore and walk on the unit, and to enjoy music, dancing, parties, socials, exercise, food, games, and talking all for short periods of time. Resident #13: Activities Progress note, completed on 12/22/10, did not indicate any individualized activity preferences. The progress note indicated the resident attended activities on and off the unit, enjoyed parties, music and games. The note indicated the resident did not need 1:1 programming. The current health care plan regarding activities indicated the goal for the resident was for him to participate in activities on and off the unit. Interventions to the plan indicated the resident enjoyed music programs, enjoyed bingo with cueing, and wandered in the hallway daily. The following activities were observed for the following days and times on the AAU unit: On 01/24/11 from 1:35 P.M. - 2:40 P.M. the only activity was snacks delivered to a few residents around 2:20 P.M. There were residents noted in the family lounge, dining room, and/or pacing in the hallways but only a compact disc of religious music was noted to be playing at maximum volume in the family lounge. There were no other activities observed. At 2:10 P.M., a housekeeper let Resident #12 off of the AAU unit. The family lounge was an approximately 8 ft by 10 ft room with two large reclining chairs and four other chairs along the edges and a desk along one side	F 248		

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F 248	Continued From page 10 of the wall with a small television and compact disc player. On 01/25/11 at 9:00 A.M. there were three residents in the family lounge. Religious music was again playing at maximum volume in the family lounge. There were five residents noted in the dining room and one resident pacing up and down the hallway. At 9:12 A.M., Unit Manager, entered the unit and turned the religious music down in volume, then she proceeded into her office. At 9:15 A.M., there were four residents pacing in the hallway and five residents in the family lounge. At 9:20 A.M., the Unit Manager, exited her office and instructed CNA #5 to do "ROM" (Range of Motion) At the same time, QMA #6 entered the unit with a medication cart and proceeded to pass medications on the AAU unit. At 9:22 A.M., CNA #5 took a resident from the dining room to their room, but did not start any activity program. At 9:25 A.M., CNA #5 reentered the family lounge with a balloon in her mouth. After blowing up the balloon, the CNA played balloon toss with 6 residents from 9:27 A.M. - 9:32 A.M., a total of 5 minutes. At 9:32 A.M., the Unit Manager, reentered the unit again and informed CNA #5 she intended to take a few residents to a music activity off of the AAU unit.	F 248		

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At 9:39 A.M., a housekeeping staff entered the unit and led Resident #7 off of the unit to listen to a music program.

At 9:41 A.M., a nursing staff member entered the unit and took Resident #13 off of the unit for a music program.

At 9:45 A.M., there were four residents in the family lounge, two were asleep and two were awake, and there was one resident walking in the hallway with QMA (Qualified Medication Aide) #6. There were no activities observed for the ten residents left on the unit.

At 9:47 A.M., QMA #6, who was the only employee on the unit at the time, gathered five residents into the family lounge, turned off the religious music, turned on the television, and handed two of the resident magazines to view.

At 10:02 A.M., the ADON (assistant director of nursing) delivered snacks onto the AAU. At 10:04 A.M., CNA #5, who had left the unit, returned to the unit. QMA #6 started preparing snacks to pass to residents.

At 10:12 A.M., after snacks had been passed, QMA #6 left the unit. The ADON was noted to sit in the family lounge with five residents. The television was playing, and the employee was sitting without interacting with the resident in a recliner. CNA #5 also left the unit. There were no activities except for the television for the residents.

At 10:22 A.M., CNA #5 reentered the unit and brought a standing lift onto the unit. QMA #6 entered the unit and pushed Resident #1 from the

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family lounge into his room. The ADON left the unit and restorative aide, Restorative Aide #11 who had entered the unit, was requested to stay on the unit while CNAs #5 and #6 were in with Resident #1. After a failed attempt to utilize the standing lift, Restorative Aide #11 and QMA #6 left the unit at 10:40 A.M., and CNA #5 remained in hallway putting wheelchair equipment back onto Resident #1's wheelchair. There were 4 residents noted pacing in the hallway and four residents in the family lounge. After fixing Resident #1's wheelchair, CNA #5 pushed Resident #1 into the family lounge at 10:50 A.M. From 10:22 - 10:50 A.M., there were no activities observed conducted for residents, except for the television, which was playing in the family lounge.

At 10:50 A.M., Resident #5 was heard making loud noises. CNA #5 responded to her room and noted Resident #10 standing in her room. CNA #5 redirected Resident #10 back into the hallway and while CNA #5 was in Resident #5's room, talking to her, Resident #10 was attempting to hit Resident #8 who was ambulating by Resident #10 holding dolls. The CNA was alerted to the situation and redirected Resident #8 away from Resident #9. CNA #5, realizing Resident #9 was agitated, held his hand and ambulated in the hallway with him from 10:50 A.M. - 11:00 A.M. While CNA #5 was ambulating with Resident #9, there were 5 residents in the family lounge. At 11:00 A.M., QMA #6 reentered the unit and CNA #5 informed her Resident #9 was upset and "belchy." QMA #6 left the unit to get Resident #10 a milkshake. CNA #5 started ambulating residents from the family lounge to the dining room, one at a time. CNA #9 brought a resident back to the unit who had been at the music activity off of the AAU unit. From 10:50 A.M. -

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F 248	Continued From page 13 11:00 A.M., there were no activities conducted for residents on the AAU unit. At 11:03 A.M., the Unit Manager #7 brought Residents #13 and #7 back from the music program, spoke briefly with Resident #10, and went into her office and closed the door. CNA #5 walked with Resident #7, directing her back to her room. At 11:06 A.M., QMA #6 reentered the unit with a milkshake and crackers for Resident #10. At 11:09 A.M., 2 male residents were pacing in the hallway, the Unit Manager was in her office, five residents were seated in the family lounge with the television on. At 11:22 A.M., CNA #5 led Resident #6 and #9 to the dining room and placed them at a c-shaped table. At 11:23 A.M., CNA #5 led Resident #12 from the family lounge to the dining room. QMA #6 pushed Resident #1 back into the hallway from the shower room. At 11:24 A.M., QMA #6 left the unit and Resident #13 and #8, who had been ambulating in the hallway, exited the unit behind her. CNA #9 brought the residents back onto the unit. At 11:28 A.M., CNA #5 directed Resident #8 to ambulate into the dining room. Unit Manager #7 exited her office and pushed Resident #1 in his wheelchair to the dining room and then Unit Manager #7 left the unit. At 11:30 A.M., CNA #5 and QMA #6 took	F 248		

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Resident #1 from the dining room, into his room, and again attempted to transfer him to the toilet with the standing lift. While both employees were in Resident #1's room, 3 residents were ambulating in the hallway, five residents were seated in the dining room, a few residents were in their rooms, and one resident was in the family lounge. Resident #8 kept grabbing ahold of Resident #7's walker.

Between 11:30 A.M. - 11:42 A.M., there were no employees supervising and/or interacting with the residents, or providing activities.

At 11:42 A.M., the ADON walked onto the unit searching for QMA #6. After realizing both employees were in with Resident #1, the ADON stayed in the dining room, but did not conduct any activities.

At 11:43 A.M., the Unit Manager #7 reentered the unit and went into her office. She did not conduct any activity programs.,

At 11:44 A.M., QMA #6 exited Resident #1's room and she and the ADON helped Resident #2, who was seated in the family lounge, to stand and ambulate to the dining room. The ADON then exited the unit.

At 11:48 A.M., QMA #6 left the unit, CNA #5 was still in the room with Resident #1, there were four residents ambulating in the hallway, five residents in the dining room in chairs, and no staff were supervising the residents or providing activities.

At 11:50 A.M., CNA #5 pushed Resident #1 in his wheelchair to the dining room. CNA #9 brought Resident #27 to the dining room from another

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nursing unit, then she left the AAU unit.

At 11:56 A.M., CNA #5 got Resident #5 out of her recliner in her room, and ambulated with her to the dining room. CNA #9 entered the unit with the food cart.

From 11:56 A.M. - 12:28 P.M., CNAs #5 and #9 delivered food trays to residents. At 12:28 P.M., CNA #5 turned on music in the dining room.

At 1:15 P.M. - 1:45 P.M., there were no activities initiated for the residents.

At 1:45 P.M., five residents were in the family lounge and the Unit Manager attempted to lead a "Visualization" type activity. While Unit Manager #7 was trying to give instructions for the activity, two of the five residents got up and left the room, and one resident was loudly verbalizing non-sensible babble. Four other residents were in the dining room without any stimulation, three residents were wandering in the hallway, and one resident was toileted by CNA #5. After five minutes of attempting to lead the "visualization" activities, the Unit Manager stopped the activity.

At 1:50 P.M., Unit Manager #7 asked CNA #5 to repeat the visualization "story" again later this afternoon.

At 2:00 P.M., there were two residents in the family lounge. One of the two residents was noted to be licking a wooden plaque. Four residents were pacing in the hall, and two nursing staff were in helping Resident #1 to get into his bed. There were two housekeeping staff sitting in the dining room with two residents. There were no activities observed conducted for residents.

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F 248	Continued From page 16 At 2:07 P.M., the ADON entered the unit, and CNA #5 came out of Resident #1's room. At 2:12 P.M., there were four residents pacing in the hallway. The Unit Manager entered the unit and went directly into her office and closed the door. QMA #6 entered the unit and started passing out snacks. At 2:14 P.M., the Unit Manager left her office and exited the unit. Five residents were observed to be pacing up and down the hallway. CNA #5 got one of the five residents ambulating in the hallway and directed them into the family lounge. At 2:15 P.M., CNA #5 got Resident #6 out of the dining room and took her into her room to the bathroom. QMA #6 was in the family lounge feeding Resident #12 his pudding. While CNA #5 was in the bathroom with Resident #6, Resident #9 walked into Resident #6's room and picked up Resident #6's pudding which had been placed on Resident #6's bedside stand. At 2:19 P.M., the Administrator entered the unit and stood in the hallway. Four residents were in the family lounge with no staff in the lounge. QMA #6 indicated both Resident #6 and #9 received a 2:00 P.M. pudding snack, so she was going to switch the bowls of pudding since Resident #9 had gotten ahold of Resident #6's pudding. At 2:27 P.M., the Administrator was still on the unit, speaking and ambulating with Resident #10. Five other residents were ambulating in the hallway. QMA #6 had briefly left the unit and returned with a treatment cart and proceeded to	F 248		

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do treatments and charting. The ADON had also entered the unit and went into the family lounge, but was not conducting any activities.

At 2:36 P.M., the administrator left the unit, four residents were ambulating up and down the hallway, a family member was walking with one of the four residents, and one resident was in the family lounge sleeping.

At 2:42, the ADON, CNA #5, and QMA #6 were all in the shower room with Resident #3. Six residents were pacing in the hallway unsupervised, and there was no activity conducted.

At 2:45 P.M., QMA #10 entered the unit and directed Residents #7 and #11 to the family lounge and then QMA #10 left the unit. At 2:46 P.M., the ADON was noted to be playing balloon toss with two residents in the family lounge. 5 residents were pacing in the hallways, and CNA #5 was still in the bathroom with Resident #3 and QMA #6 was in a resident's room applying a treatment. At 2:47 P.M., Resident #3 reentered the hallway and was walking into Resident #10, who had been ambulating in the hallway. Resident #10 was noted to push Resident #3 away from him. The Unit Manager, who happened to have entered the unit, attempted to redirect Resident #3 away from Resident #10 but after being unsuccessful, Unit Manager #7 proceeded into her office and shut the door.

At 2:51 P.M., the ADON was still noted in the family lounge to be playing balloon toss with four residents. The television was also noted to be playing.

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F 248	Continued From page 18 On 01/26/11 at 8:30 A.M., two CNA'S were observed to be working on the AAU unit. Both CNA'S were observed to be toileting residents from 8:30 A.M. - 8:49 A.M. There was big band music playing at maximum volume in the family lounge. At 8:49 A.M., the Unit Manager entered the unit and informed CNA #5 of the residents she wanted to go to the "Exercises" activity off of the unit. At 8:52 A.M., the Unit Manager took Resident #7 off of the unit for an activity. At 9:00 A.M., QMA #6 took Resident #13 off of the unit for an activity. At 9:08 A.M., CNA #8 was noted to play balloon toss with residents in the family lounge. She played balloon toss from 9:08 A.M. - 9:20 A.M. At 9:30 A.M., CNA #5 was observed to be in the family lounge handing four of five residents in the lounge pieces of material. At 9:52 A.M., CNAs #5 AND #8 took the stand up lift and Resident #1 and attempted to transfer him to the bathroom. The lift was not functioning properly, and both employees were noted to be in Resident #1's room from 9:52 A.M. - 10:10 A.M. While staff were in Resident #1's room, the Dietary Manager had entered the unit to replace a name tag on a resident's room door and observed one of the residents had had a bowel movement in the doorway to room #233. There were four residents pacing in the hallways, and the dietary manager indicated he was "on guard" to make sure no residents stepped in the feces until housekeeping arrived to clean up the mess. There were six other residents noted in the family lounge. The Unit Manager entered the unit at	F 248		

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F 248	Continued From page 19 10:10 A.M., but went straight to her office and shut the door. There were no activities provided for the residents who were not taken off of the unit from 9:52 - 10:10 A.M. Other than some snacks being passed, there was no activity noted on the AAU unit until 10:53 A.M., when CNA #8 read recipes to residents in the dining room. At 11:10 A.M., music was playing in the dining room, there were eight residents seated in the dining room, and three of the eight had been given magazines to look through. At 11:43 A.M., the meal cart was delivered to the unit. Interview with the Unit Manager on 01/27/11 at 2:10 P.M., regarding the lack of activities for the AAU unit, indicated the activities scheduled were not on a set schedule as far as timing. She indicated she was only responsible for setting up the programming, but the CNA's were responsible for implementing the activities. She indicated she was also responsible for all social service needs of the entire second floor and had several responsibilities elsewhere in the building and could not always supervise activities on the AAU unit. She did not indicate how the certified nursing assistants were to have time to conduct the activities when there were so many incontinent residents to take to the bathroom before and after meals. At no time did staff involve Resident #2 with his care plan goals regarding activities. The resident's wife was noted to visit on 01/27/11 and was involved in personally showering the resident.	F 248		

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Although Resident #3 was encouraged to participate in the few activities conducted on the AAU unit, there were very few activities provided for the resident, and she was observed to spend large amounts of time wandering aimlessly throughout the unit.

Resident #5 was observed to spend most of the time in her room in a recliner. On 01/26/11 she was placed in the family lounge, but there was no matching or sorting type activity conducted and the resident was only observed to have participated passively in one balloon toss activity. The resident's husband was not observed to have visited.

Resident #6 was taken off of the unit once for an activity programs - an exercise program, but there were no crafts, parties, spiritual activities or games offered while she was on the unit, except for balloon toss. One of the balloon toss activities occurred while she was off the unit at another activity.

Resident #7 was taken off the unit twice for other activity programs, but there were no spiritual groups, parties, and very little "social" hour activities. The resident was observed to refuse at times to enter the family lounge if it was crowded. It was unclear if the resident was afraid of not being able to get her walker through the other residents, did not like crowds, or did not like noisy places, as often the music playing was at a very high volume in a very small crowded room.

Resident #8 would participate in any of the few activities offered on the AAU unit and was observed to spend much of her time holding dolls while she sat and/or wandered on the unit.

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Resident #9 was noted to spend much of her time wandering on the unit, did respond socially when greeted, and did for very short periods of time participate in balloon toss and folded fabric when it was handed to her. The resident talked through the instructions for "visualization" and appeared to be unaware of the purpose of the activity.

Resident #10 was not taken off the unit to see the birds or taken to the chapel. The resident was observed to spend most of his time wandering in the hallway and did not participate in the few activities that were conducted. The resident did "sing" when the Administrator stood and conversed with him on a 1:1 basis. The resident did look into the family lounge but did not enter the room. The resident was noted to get upset if other residents entered his personal space and was noted to gesture and point at residents who were irritating him as he wandered.

Resident #11 was not engaged in reminiscing or conversations about work, there was no "busy box with gadgets" observed for Resident #11, and he did not participate in many of the few activities offered.

Resident #12 was noted to spend large amounts of time sleeping in the family lounge. Staff did attempt to wake him up and encourage participation in the few activities that were conducted.

Resident #13 was taken off the unit for two activity programs and was let off the unit once where he was noted to stand by the other side of the door to the AAU for awhile and eventually sat in a rocking chair on the "front porch" area and

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F 248	Continued From page 22 fell asleep. The resident was not taken to Bingo activities, and the resident was observed to only participate in one episode of balloon toss. Although snacks were consistently offered to residents twice a day, most of the residents receiving a snack required staff to feed them their snacks, not all 12 residents were offered snacks, and there was no other activity offered for residents who did not receive snacks. Although music was played loudly and passively for residents, there was no music program provided which allowed residents to participate and/or sing along. Staff were not noted to encourage any resident participation in music programs. The "visualization" activity provided for 5 minutes on 01/25/11 appeared to be too complicated for residents with advanced dementia and it was unclear if other residents could even hear the instructions due to the constant vocalizations from Resident #9. Although balloon toss occurred twice during the week, one of the two times was very brief and did not involve all of the residents. Although residents were given fabric to hold on one occasion, there were no instructions and very little staff to resident interaction during the time regarding the fabric.	F 248	**F 272 Comprehensive Assessements** It is the intent of this facility to ensure that assessments for the need of a Finger Food Diet. **Corrective Action for affected residents** Resident # 58 has been assessed by Occupational Therapy for the need of a Finger Food Diet on Feb 14, 2011. **Identification and corrective action taken for other residents potentially affected** 100% review of all other residents assessed and no issues identified. **Measures/Systemic changes to ensure that the deficient practice does not recur** All nursing staff inserviced on residents needs during mealtimes completed on Feb 18, 2011.	
F 272 SS=D	3.1-33(a) 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically	F 272		

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F 272	Continued From page 23 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assess the need for a Finger Food Diet for 1 of 1 resident (Resident #58) in a total sample of 15. Findings include:	F 272	Audits will be completed 5 times weekly by Rehabilitation Director/designee and will be reviewed during morning meeting to ensure supervision and cueing occurred. **Monitoring of corrective action to ensure the practice will not recur- QA program in place** Daily monitoring audits will be completed and any issues identified will be addressed immediately. Any issues identified will be discussed in the quarterly Quality Assurance meeting. Rehabilitation/Designee responsible for ongoing compliance. **Completion Date: February 26, 2011**	

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F 272	Continued From page 24 Review of the clinical record of Resident #58 on 1/26/11 at 9:50 a.m., indicated the following: diagnoses included, but were not limited to, cerebrovascular accident and dementia. A current physician order for Resident #58, dated 1/4/11, indicated Resident #58 was to receive a Mechanical Soft Diet. A Minimum Data Set (MDS) assessment for Resident #58, dated 11/12/10, indicated she was independent in eating with setup help only. The MDS assessment also indicated she experienced impairment with her functional range of motion in her upper extremity on one side. A current facility care plan for Resident #58, dated 8/31/10, indicated she required assistance for ADL's (activities of daily living). Approaches to the problem included, but were not limited to, monitor during task for frustration and offer assist and encouragement and refer to PT/OT (physical therapy/occupational therapy) as indicated. Nurse's notes for Resident #58, dated 11/19/10, indicated she preferred to perform activities by herself. The nurse's notes also indicated she required extensive cueing during mealtime. Nurse's notes for Resident #58, dated 11/25/10, indicated a staff member attempted to assist her with placing food onto her spoon at dinner and she seemed to get upset and started crying. During an observation of the lunch meal on 1/24/11 at 12:20 p.m., Resident #58 was observed to receive a Mechanical Soft Diet of Salisbury steak with gravy, potato medley, green beans, and brownie as menued as well as diced	F 272		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 25 pears and a container of yogurt. Resident #58 was observed to eat the foods served with her fingers and attempted to drink her yogurt from the plastic yogurt container. She did not attempt to use her eating utensils. During an observation of the lunch meal on 1/25/11 at 12:24 p.m., Resident #58 was observed to receive a Mechanical Soft Diet of herbed pork roast with gravy, baked sweet potato, Harvard beets and cherry cobbler as menued as well as a container of yogurt. Resident #58 was observed to eat the foods served with her fingers and at one time during the meal had cherry cobbler all over her fingers. During an observation of the evening meal on 1/25/10 at 5:50 p.m., Resident #58 was observed to receive a Mechanical Soft Diet of pizza, tossed salad, diced pears, and a cookie as menued as well as a container of yogurt. At 5:55 p.m., she was observed eating the diced pears and tossed salad with dressing with her fingers. At 6:02 p.m., she was directed by LPN #14 to eat her diced pears with a spoon. After taking one bite with the spoon, Resident #58 was observed to place the spoon down on the table. From 6:10 p.m. to 6:22 p.m., Resident #58 was observed to continually eat her food with her fingers and attempt to drink her yogurt from the plastic yogurt container. At 6:22 p.m., Resident #58 was observed to eat the chocolate ice cream placed at her table setting with her fingers. She again was directed to use a spoon to eat her ice cream by LPN #14. The Housekeeping Supervisor #19, who was close to the dining table of Resident #58 during the evening meal, was interviewed on 1/25/11 at 6:28 p.m. During the interview she indicated	F 272		

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	155159	A. BUILDING _____ B. WING _____	01/27/2011

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F 272	Continued From page 26 Resident #58 has preferred to eat with her fingers, even more since she suffered her stroke. During an observation of the lunch meal on 1/26/11 at 12:10 p.m., Resident #58 was observed to receive a Mechanical Soft Diet of breaded steak fingers, mashed potatoes, carrots, and butterscotch pudding as menued as well as a container of yogurt. At 12:15 p.m., Resident #58 was observed to eat her carrots with her fingers and attempted to drink her yogurt from the plastic container. At 12:30 p.m., Resident #58 was observed to start eating her mashed potatoes with her fingers and was directed by LPN #15 to use her spoon. LPN #14 and LPN #15 were interviewed on 1/26/11 at 2:10 p.m. During the interview they indicated Resident #15 was very independent and preferred to feed herself. They also indicated she always wanted to use her fingers to feed herself and would place her spoon down on the the table even if it were placed in her hands. The facility Consultant Dietitian was interviewed on 1/26/11 at 2:15 p.m. During the interview she indicated the facility did not have a Finger Food Diet. She also indicated she had not been informed by staff Resident #58 preferred to eat with her fingers. She further indicated if informed she would have asked speech or occupational therapy for an evaluation. Certified Occupational Therapy Assistant (COTA) #17 was interviewed on 1/26/11 at 2:50 p.m. During the interview she indicated therapy had previously worked with Resident #58, but had not been asked to assess her for a Finger Food Diet. She also indicated she had noticed Resident #58	F 272		

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F 272	Continued From page 27 preferred to eat with her fingers and would probably benefit from a Finger Food Diet. Restorative Aide #18 was interviewed on 1/27/11 at 12:00 p.m. During the interview he indicated a Finger Food Diet had been suggested by therapy to the facility for Resident #58 but nothing happened. He also indicated Resident #58 preferred to eat with her fingers and would not let anyone feed her. The Director of Nursing was interviewed on 1/27/11 at 2:15 p.m. During the interview she indicated referrals for therapy assessments were made by the interdisciplinary team. She further indicated any department could make a referral and therapy could also decide to assess a resident based on their observations. The 2006 Indiana Diet Manual indicated a Finger Food Diet "...may be used for those who feed themselves most easily by using few utensils, such as...adults with dementia...." 3.1-31(a) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure physician's orders and the plan of care were followed for 3 of	F 272	**F 282 Services By Qualified Persons/Per Care Plan** It is the intent of the facility to ensure physician's orders and the plan of care are followed. **Corrective Action for affected residents** Resident #27's Ted Hose applied to CNA Pocket Worksheet on January 28, 2011. Residents # 1 and #5 staff educated as to toileting schedule on January 29, 2011. **Identification and corrective action taken for other residents potentially affected** All other residents on AACU were assessed on February 17, 2011 and no other issues identified. **Measures/Systemic changes to ensure that the deficient practice does not recur**	
F 282 SS=D		F 282		

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F 282	Continued From page 28 15 residents reviewed related to physician's orders and plan of care in a sample of 15. The deficient practice affected 1 of 2 residents observed for wearing TED (thrombo-embolytic deterrent) hose (Resident #27) and 2 of 5 residents reviewed related to incontinence needs. (Residents #1 and #5). Findings include: 1. The record for Resident #27 was reviewed on 1/26/11 at 9:00 a.m. Diagnoses included, but were not limited to, dementia and hypertension. A physician order, dated 9/10/10, indicated Resident #27 was to wear knee high TED hose [tight elastic stockings worn to promote blood flow and reduce blood from clotting] daily. The order indicated the TED hose were to be put on in the morning and removed at bedtime. Resident #27 was observed on 1/26/11 at 9:00 a.m., sitting in a wheelchair in the activity/dining room on the second floor. The resident was not observed to be wearing TED hose. Resident #27 was observed on 1/26/11 at 10:20 a.m. sitting in a wheelchair in the activity/dining room on the second floor. The resident was not observed to be wearing TED hose. Resident #27 was observed on 1/26/11 at 1:45 p.m., in his room, lying on his bed. The resident was not observed to be wearing TED hose. Resident #27 was observed on 1/27/11 at 9:45 a.m., sitting in a wheelchair in the activity/dining room on the second floor. The resident was not observed to be wearing TED hose.	F 282	All nursing staff educated on toileting program completed on February 18, 2011. DON/Designee will audit incontinence needs and TED hose 5 times per week. Audits will be discussed in weekly Persons At Risk meetings. **Monitoring of corrective action to ensure the practice will not recur- QA program in place** Audits will be completed and concerns will be addressed immediately with staff. Any issues will be discussed in quarterly QA meetings. DON/Designee will be responsible for ongoing compliance. **Completion Date: February 26, 2011**	

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F 282	Continued From page 29 Resident #27 was observed on 1/27/11 at 11:45 a.m., sitting in a wheelchair in his room on the second floor. The resident was not observed to be wearing TED hose. LPN #11 was interviewed on 1/27/11 at 11:20 a.m. During the interview, the LPN indicated nurses and Certified Nursing Assistants [CNAs] were responsible for ensuring residents wore TED hose if they were ordered by the physician. CNA #9 was interviewed on 1/27/11 at 11:30 a.m. During the interview, CNA #9 indicated CNA's could find out which residents were to wear TED hose by referring to their assignment sheets. The CNA indicated items such as TED hose were indicated on the assignment sheets. The assignment sheet provided by CNA #9 did not indicate Resident #27 was to wear TED hose. CNA #9 further indicated she was not aware that Resident #27 was to wear TED hose. The Director of Nursing [DN] was interviewed on 1/27/11 at 2:45 p.m. During the interview, the DN indicated the nurses had the primary responsibility of ensuring residents that had orders for TED hose were wearing them and the nurses were to put them on the residents. 2. During the initial tour of the facility, conducted on 01/24/11 between 10:20 A.M. - 10:55 A.M. the ADON and the unit manager, employee #7 indicated Resident #1 was restrained in a wheelchair, incontinent of his bowels and bladder and required moderate to maximum staff assistance to toilet.	F 282		

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F 282	Continued From page 30 The clinical record for Resident #1 was reviewed on 01/25/11 at 9:10 A.M. The most recent MDS assessment for Resident #1, completed on 01/18/11, indicated the resident was always incontinent of his bowels and bladder, required total staff assistance for transferring and toileting needs. The current health care plans for Resident #1, current through 02/05/11, indicated the resident was to be toileted per "t-time"schedule and as needed, and was to be toileted upon rising, before and after meals, and at bedtime. On 01/25/11 at 10:22 A.M., nursing staff attempted to toilet Resident #1. The toileting was aborted when the standing lift would not function properly. The resident was then toileted at 11:30 A.M. QMA #6 indicated the resident had been toileted when he was gotten up in the morning before breakfast. On 01/26/11 at 9:52 A.M., Resident #1 was transferred with the standing lift to the toilet. The resident was not toileted before the noon meal. 3. During the initial tour of the facility, conducted on 01/24/11 between 10:20 A.M. - 10:55 A.M. the ADON and the unit manager, employee #7 indicated Resident #5 was incontinent, toileted by staff, and required extensive staff assistance for toileting needs and ambulation needs. On 01/25/11 at 9:00 A.M., Resident #5 was noted to still be in the dining room in a chair asleep. The resident was placed in her recliner in her chair between 9:00 A.M. - 9:45 A.M. The resident remained in her room in her recliner until 11:56 A.M. when CNA#5 ambulated her directly from	F 282		

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F 282	Continued From page 31 her recliner into the dining room. On 01/26/11 at 8:35 A.M. Resident #5 was noted to be seated in a recliner in the family lounge. She remained in the family lounge until 10:31 A.M., when CNA #5 took her directly to the dining room for activities. Resident #5 remained in the dining room without being toileted until the noon meal was delivered. The clinical record for Resident #5 was reviewed on 01/24/11 at 2:25 P.M. The most recent Minimum Data Set (MDS) assessment, completed on 01/10/11, indicated the resident was continent of bowels and bladder, however, the full MDS, completed on 07/28/10 indicated the resident was totally incontinent of her bowels and bladder. The current health care plan for Resident #5, initiated on 01/25/11 indicated the resident was to be toileted upon rising, before and after meals, at bedtime, and as needed.	F 282		
F 323 SS=G	3.1-35(g)(2) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to provide adequate	F 323	**F 323 Free of Accident/HazardsSupervision/ Devices** The intent of this facility is to provide adequate supervision to prevent falls and to provide adequate supervision to prevent accidents.	

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F 323	Continued From page 32 supervision to prevent a fall with injury (fractured hip) for 1 of 3 closed records reviewed. (Resident #4) In addition, the facility failed to provide adequate supervision to prevent accidents for 12 of 12 residents residing on the Advanced Alzheimer's Unit (AAU). (Residents #1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, and 13) and 1 resident who came to the AAu for dining. (Resident #27) Findings include: 1. Review, on 01/27/11 at 10:00 A.M. , of the closed record for Resident #4, indicated the resident had fallen on 01/04/11. On 01/06/11, the resident was transferred to an acute care center emergency room and diagnosed with a deep vein thrombosis (DVT) of her left knee. The resident returned from the acute care facility emergency room, on 01/06/11, with the following new orders: "ASA (aspirin) 81 mg daily, walker to aid ambulation, pt (patient) to be up only with assistance, bed monitor to prevent pt getting up alone, rails to be up to prevent falls." The resident's health care plans were not updated to reflect the new physician orders from 01/06/11. The resident was screened on 01/10/11, by the physical therapy department and added to their caseload due to her fall on 01/04/11. The resident was treated by physical therapy for eight days for standing balance, transferring and mobility needs. Nursing notes, dated 01/19/11 at 3:00 P.M., indicated the following: "Pt was walking in hall on back unit (AAU) Resident #93784 (Resident #10) pushed pts arm, she lost her balance et fell on right hip. Staff alerted writer...."	F 323	**Corrective Action for affected residents** Resident #3, #6, #27 and # 9 are being cued and supervised throughout meal services. Activity Programming for all residents residing on the AACU was evaluated on February 10, 2011 and will be implemented to meet the needs of the residents to include social, physical, spiritual and sensory stimulation. Personal care as defined in ISDH Alzheimer's Dementia seminar's Activity book has also been added to the Activity schedule. Dementia seminar was conducted on October 14, 2010 for all longterm care providers and State Surveyors. Staffing ratios that were 1 staff member to 6 residents have been evaluated. **Identification and corrective action taken for other residents potentially affected** No other residents were identified. **Measures/Systemic changes to ensure that the deficient practice does not recur**	

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F 323	Continued From page 33 Subsequent nursing notes indicated an x-ray was obtained and indicated the resident had a hip fracture and she was subsequently transferred to an acute care center for treatment. Interview with the DON (Director of Nursing), ADON (Assistant Director of Nursing), and Rehab manager, COTA (Certified Occupational Therapy Assistant) #14, on 01/27/11 at 2:30 P.M. indicated the "assistance" the resident required was the walker, not staff "assistance." They indicated the resident had a bed alarm, so they knew when the resident was up out of bed and knew to make sure the resident had her walker with her. The DON indicated the resident was not being assisted to ambulate when she fell on 01/19/11 but staff were in the hallway getting ready to take another resident into the shower room for a shower when they saw Resident #4 fall. Interview on 1/27/11 at 11:30 a.m. with the Physical Therapist #16, who had worked with Resident #4, indicated while the resident was making progress, she still required "contact guard" assistance in the therapy room mostly because she was not capable of physically placing the walker correctly and mentally needed cues to remember to utilize the walker and instructions on how to utilize the walker. She indicated she did not instruct the nursing staff to allow the resident to ambulate independently with the walker. 2. On 01/24/11 at 11:53 A.M., the meal trays were delivered on a cart to the AAU dining room. The meal tray for Resident #6 was delivered at 11:53 A.M. The resident was noted to be sleeping at a c-shaped table and did not respond to verbal cues to "wake up" and "eat." The meal	F 323	All staffing inservices will be completed Feb 18, 2011. Daily audits will be completed by Administrator/designee and will be reviewed during Daily Stand Up meeting to ensure supervision and cueing occurred. Alzhemier's Care Unit Director/ designee will monitor activity schedule to ensure compliance 3 times a week. **Monitoring of corrective action to ensure the practice will not recur-QA program in place** Daily monitoring audits for supervision and cueing will be completed and any issues identified will be addressed immediately. Administrator/Designee responsible for ongoing compliance. Activity audits will be completed and discussed weekly during Persons At Risk meeting. Any issues identified will be immediately addressed with staff. Findings will be discussed in quarterly QA meetings. Alzheimer's Care Unit Director/designee will be responsible for ongoing compliance. **Completion Date: February 26, 2011**	

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F 323	Continued From page 34 tray for Resident #3 was delivered to her and set up for her and she was instructed to eat. The resident was noted to eat with her fingers and pick up her dessert plate, on which she had picked at a piece of cake, and lick the plate. CNA (Certified Nursing Assistant) #5, noticed Resident #3 licking her dessert plate but only commented "Poor (resident's name) - she really likes her sweets." The CNA did not redirect the resident from licking her plate or from eating with her fingers. At 12:15 P.M., the meal tray was delivered to Resident #9 who was sleeping at a c-shaped table. The resident was awakened and instructed to eat. The resident then proceeded to stick the handle part of her fork and her piece of cake into a plastic mug and fell back asleep. Both Residents #6 and 9 were not assisted to eat until 12:19 P.M. On 01/25/11 at 9:00 A.M., there were three residents in the family lounge. Religious music was again playing at maximum volume in the family lounge. There were five residents noted in the dining room and one resident pacing up and down the hallway. CNA #5 was observed to be getting residents out of the dining room and bringing them down to the family lounge. There were no other staff noted on the unit at the time and no supervision for residents in the family lounge while CNA #5 was in the dining room. At 9:12 A.M., the Unit Manager #7, entered the unit and turned the religious music down in volume, then she proceeded into her office. She did not provide supervision for residents on the unit. At 9:15 A.M., there were four residents pacing in	F 323		

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F 323	Continued From page 35 the hallway and five residents in the family lounge. CNA#5 was in the dining room clearing up breakfast items. At 9:20 A.M., the Unit Manager #7 exited her office and instructed CNA #5, who was in the hallway, to do "ROM" (Range of Motion) At the same time, QMA #6 entered the unit with a medication cart and proceeded to pass medications on the AAU. At 9:45 A.M., there were four residents in the family lounge, two were asleep and two were awake, and there was one resident walking in the hallway with QMA #6. There was no supervision for residents in the family lounge as QMA #6 was in the hallway walking in a train style with Resident #9. At 9:47 A.M., QMA #6, who was the only employee on the unit at the time, gathered five residents into the family lounge, turned off the religious music, turned on the television, and handed two of the resident magazines to view. While QMA #6 was in the family lounge and CNA #5 was off of the unit, there was no supervision for the two residents who were now pacing in the hallway. At 10:02 A.M., the ADON, assistant director of nursing, delivered snacks onto the AAU. At 10:04 A.M., CNA #5, who had left the unit, returned to the unit. QMA #6 started preparing snacks to pass to residents. At 10:12 A.M., after snacks had been passed, QMA #6 left the unit. The ADON was noted to sit in the family lounge with five residents. The television was playing and the employee was	F 323		

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F 323	Continued From page 36	F 323		

sitting in a recliner without interacting with the residents. CNA #5 also left the unit. There was no supervision for the residents in the hallways pacing or in their rooms.

At 10:50 A.M., Resident #5 was heard making loud noises. CNA #5, who had been in the family lounge, responded to her room and noted Resident #10 standing in her room. CNA #5 redirected Resident #10 back into the hallway and while CNA #5 was in Resident #5's room, talking to her, Resident #10 was attempting to hit Resident #8 who was ambulating by Resident #10 holding dolls. CNA #5 was alerted to the situation and redirected Resident #8 away from Resident #9. CNA #5, realizing Resident #10 was agitated, held his hand and ambulated in the hallway with him from 10:50 A.M. - 11:00 A.M. While CNA #5 was ambulating with Resident #9, there were five residents in the family lounge. There was no supervision for the five residents in the family lounge.

At 11:03 A.M., the Unit Manager #7 brought Residents #13 and #7 back from the music program, spoke briefly with Resident #10, and went into her office and closed the door. CNA #5 walked with Resident #7, directing her back to her room and assisted her to the toilet. From 11:03 A.M. - 11:06 A.M., there was no direct supervision for residents in the dining room, hallway, or family lounge.

At 11:06 A.M., QMA #6 reentered the unit with a milkshake and crackers for Resident #10.

At 11:09 A.M., two male residents were pacing in the hallway, Unit Manager #7 was in her office with the door closed, CNA #5 was in Resident

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 37 #7's room, five residents were seated in the family lounge with the television on and no direct staff supervision. At 11:19 A.M., QMA #6 took Resident #1 in his wheelchair, into the shower room to weigh him. CNA #5 walked Resident #7 and #13 to the dining room. At 11:24 A.M., QMA #6 left the unit. At 11:28 A.M., CNA #5 directed Resident #8 to ambulate into the dining room. Unit Manager #7 exited her office and pushed Resident #1 in his wheelchair to the dining room and then Unit Manager #7 left the unit. At 11:30 A.M., CNA #5 and QMA #6 , who had reentered the unit, took Resident #1 from the dining room, into his room, and again attempted to transfer him to the toilet with the standing lift. While both employees were in Resident #1's room, 3 residents were ambulating in the hallway, five residents were seated in the dining room, a few residents were in their rooms, and one resident was in the family lounge. Resident #8 kept grabbing ahold of Resident #7's walker. Between 11:30 A.M. - 11:42 A.M., there were no employees supervising and/or interacting with the residents, because both CNA #5 and QMA #6 were in Resident #1's room. At 11:42 A.M., the ADON walked onto the unit searching for QMA #6. After realizing both employees were in with Resident #1, the ADON stayed in the dining room, but there was no direct supervision for residents in the hallway or in the family lounge.	F 323		

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F 323	Continued From page 38 At 11:43 A.M., Unit Manager #7 reentered the unit, and although she looked at Resident #8 holding onto Resident #7's walker as the two residents ambulated in the hallway, she walked directly to her office without intervening. At 11:44 A.M., QMA #6 exited Resident #1's room and she and the ADON helped Resident #2, who was seated in the family lounge, to stand and ambulate to the dining room. The ADON then exited the unit. At 11:48 A.M., QMA #6 left the unit, CNA #5 was still in the room with Resident #1, there were four residents ambulating in the hallway, five residents in the dining room in chairs, and no staff were supervising the residents. At 11:50 A.M., CNA #5 pushed Resident #1 in his wheelchair to the dining room. CNA #9 brought Resident #27 to the dining room from another nursing unit, then she left the AAU. At 11:56 A.M., CNA #5 got Resident #5 out of her recliner in her room, and ambulated with her to the dining room. CNA #9 entered the unit with the food cart. While CNA #5 was getting Resident #5 out of her recliner in her room, there was no supervision for the residents in the dining room or in the hallway ambulating. At 12:06 P.M., Resident #3's tray was delivered to her. The staff put butter on her sweet potato and left the resident to feed herself. The resident was noted to eat her cherry cobbler dessert directly out of the bowl without using silverware. The dessert dribbled down the resident's chin, clothes, and was noted all over her fingers. She did not receive any cues or supervision to use her	F 323		

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F 323	Continued From page 39 silverware. At 12:21 P.M., Resident #27 was noted to be sitting at a table without any staff cues or assistance. The resident's left hand was noted to be lying in his pureed meat and gravy. The resident was attempting to feed himself with his right hand but was noted to have dribbled most of his dessert and vegetable down his chin. CNA #5 left the dining room to deliver a tray to Resident #10's room. She returned at 12:26. From 12:21 P.M. - 12:26 P.M., QMA #6 was in the dining room passing out meal trays but was not supervising Residents #27 or #3. At 12:26 P.M., both CNA #5 and QMA #6 were seated a two c-shaped tables with four residents for each to feed and/or assist. Resident #3 was taking food off of Resident #7's meal tray, and a family member for another resident tried to intervene. There were no observations made from 12:26 P.M. - 1:15 P.M. At 1:15 P.M., CNA #5 was observed the dining room cleaning up from lunch and no staff supervision for residents in the hallway or family lounge. At 1:45 P.M., five residents were in the family lounge and Unit Manager, who was also in the family lounge, attempted to lead a "Visualization" type activity. While Unit Manager was trying to give instructions for the activity, two of the five residents got up and left the room, and one resident was loudly verbalizing non-sensible babble. Four other residents were in the dining room without any stimulation, three residents	F 323		

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F 323	Continued From page 40 were wandering in the hallway, and CNA #5 was in a resident room assisting a resident to the toilet. There was no direct supervision for residents in the hallway or dining room. At 1:50 P.M., Unit Manager #7 asked CNA #5, who had reentered the hallway, to repeat the visualization "story" again later this afternoon, and she left the unit. At 2:00 P.M., there were two residents in the family lounge. One of the two residents was noted to be licking a wooden plaque. Four residents were pacing in the hall, and two nursing staff, CNA #5 and QMA #6 were in helping Resident #1 to get into his bed. There were two housekeeping staff sitting in the dining room with two residents. There was no staff supervision for the residents in the hallway or in the family lounge. At 2:07 P.M., the ADON entered the unit, and CNA #5 came out of Resident #1's room. At 2:12 P.M., there were four residents pacing in the hallway. Unit Manager #7 entered the unit and went directly into her office and closed the door. QMA #6 entered the unit and started passing out snacks. At 2:14 P.M., Unit Manager left her office and exited the unit. Five residents were noted to be pacing up and down the hallway. CNA #5 got one of the five residents ambulating in the hallway and directed them into the family lounge. At 2:15 P.M., CNA #5 got Resident #6 out of the dining room and took her into her room to the bathroom. QMA #6 was in the family lounge	F 323		

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F 323	Continued From page 41 feeding Resident #12 his pudding. While, CNA #5 was in the bathroom with Resident #6, Resident #9 walked into Resident #6's room and picked up Resident #6's pudding which had been placed on Resident #6's bedside stand. There was no staff supervision for residents ambulating the hallway. At 2:19 P.M., the Administrator entered the unit and stood in the hallway. Four residents were in the family lounge with no staff in the lounge. QMA #6 indicated both Resident #6 and #9 received a 2:00 P.M. pudding, so she was going to switch the bowls of pudding, since Resident #9 had gotten ahold of Resident #6's pudding. At 2:27 P.M., the Administrator was still on the unit, speaking and ambulating with Resident #10. Five other residents were ambulating in the hallway. QMA #6 had briefly left the unit and returned with a treatment cart and proceeded to do treatments and charting. The ADON had also entered the unit and went into the family lounge. At 2:36 P.M., the administrator left the unit, four residents were ambulating up and down the hallway, a family member was walking with one of the four residents, and one resident was in the family lounge sleeping. At 2:42 P.M., the ADON, CNA #5, and QMA #6 were all in the shower room with Resident #3. Six residents were pacing in the hallway unsupervised. At 2:45 P.M.., QMA #10 entered the unit and directed Residents #7 and #11 to the family lounge and then staff member #10 left the unit. At 2:46 P.M., the ADON was noted to be playing	F 323		

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F 323	Continued From page 42 balloon toss with two residents in the family lounge. 5 residents were pacing in the hallways, and CNA #5 was still in the bathroom with Resident #3 and QMA #6 was in a resident's room applying a treatment. At 2:47 P.M., Resident #3 reentered the hallway and was walking into Resident #10, who had been ambulating in the hallway. Resident #10 was noted to push Resident #3 away from him. Unit Manager #7, who happened to have entered the unit, attempted to redirect Resident #3 away from Resident #10 but after being unsuccessful, Unit Manager #7 proceeded into her office and shut the door. There was then no supervision for the residents in the hallway ambulating. On 01/26/11 at 8:30 A.M., CNAs #5 and #8 were observed to be working on the AAU. Both CNA'S were noted to be toileting residents from 8:30 A.M. - 8:49 A.M. There was big band music playing at maximum volume in the family lounge. At 8:49 A.M., Unit Manager entered the unit and informed CNA #5 of the residents she wanted to go to the "Exercises" activity off of the unit. While the CNAs were in various resident rooms toileting residents, there was no direct supervision for the residents At 8:52 A.M., Unit Manager #7 took Resident #7 off of the unit for an activity. At 9:00 A.M., QMA #6 took Resident #13 off of the unit for an activity. At 9:08 A.M., CNA #8 was noted to play balloon toss with residents in the family lounge. She played balloon toss from 9:08 A.M. - 9:20 A.M. While she was in the family lounge, there was no supervision for residents in the hallway or dining room.	F 323		

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F 323	Continued From page 43 At 9:30 A.M., CNA #5 was noted to be in the family lounge handing four of five residents in the lounge pieces of material. At 9:52 A.M., CNA #5 AND #8 took the stand up lift and Resident #1 and attempted to transfer him to the bathroom. Both employees were noted to be in Resident #1's room from 9:52 A.M. - 10:10 A.M. While staff were in Resident #1's room, the Dietary Manager had entered the unit to replace a name tag on a resident's door and noted one of the residents had had a bowel movement in the doorway to room #233. There were four residents pacing in the hallways and the dietary manager indicated he was "on guard" to make sure no residents stepped in the feces until housekeeping arrived to clean up the mess. There were six other residents noted in the family lounge without supervision. Unit Manager #7 entered the unit at 10:10 A.M., but went straight to her office and shut the door. Interview with the Administrator, on 01/27/11 at 2:15 P.M. indicated there were always two full time staff scheduled on the AAU at all times for only 12 residents and she felt the staffing was adequate. She indicated there was always a possibility for accidents no matter how many staff were available and no matter what type of residents were served. On 1/27/11 at 2:45 p.m., review of the most recent Minimum Data Set (MDS) assessments for all current residents residing on the AAU indicated the following: All 12 were cognitively impaired, 9 of 12 wandered in the hallway occasionally to frequently, 4 residents were at risk for falls, all 12	F 323		

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F 323	Continued From page 44 required extensive staff assistance for dressing and hygiene needs, 11 of 12 required extensive staff assistance for toilet use, 1 of 12 residents was in a wheelchair and required two staff assistance for transferring needs, 2 of 12 required staff assistance of 1 for ambulation needs, and 9 of 12 required extensive staff assistance for eating needs. In addition, Resident #27, who was brought to the dining room from another nursing unit for meals, also required extensive staff assistance of 1 for eating needs. The AAU was one hallway with a shorter wider hallway on one end. The dining room was at the south end of the hallway, the short hallway and the family lounge were on the north end of the hallway. There were no video cameras or mirrors noted to assist staff with visualization on the AAU. 3.1-45(a)(2)	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	**F329 Drug regimen is free from unnecessary drugs** It is the intent of this facility to adequately monitor medical symptoms for which a psychotropic medication is given. **Corrective Action for Affected Residents** Res #13's behavior monitoring sheet has been modified. **Identification and corrective action taken for other residents potentially affected** 100% audit for residents receiving psychotropic medications with no other concerns.	

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F 329	Continued From page 45 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to adequately monitor medical symptoms for which a psychotropic medication was given for 1 of 7 residents reviewed for psychotropic medication use in a sample of 15. (Resident #13) Findings include: During the initial tour of the facility, conducted on 01/24/11 between 10:20 A.M. - 10:55 A.M., the Alzheimer's unit manager and the ADON, indicated Resident #13 received Depakote (an anti-seizure medication also given for mood stabilization) and Fazaclo (an antipsychotic medication given for behavior control) for "wandering." The unit manager indicated Resident #13 had not displayed any "behaviors" but did wander daily. Resident #13 was observed during the day on 01/24/11 at 2:00 P.M., 01/25/11 at 9:12 A.M., and 01/26/11 at 8:48 A.M., to ambulate independently in the hallways of the AAU (Advanced alzheimer's unit). The resident was not noted to get agitated, anxious, or upset at anytime.	F 329	**Measures/Systemic changes to ensure that the deficient practice does not recur** Social Services inservices will be completed Feb 18, 2011. Audits will be performed by Alzheimer Care Unit Director 3 times per week to ensure documentation has been completed. Monthly behavioral forms will be implemented by Social Services. **Monitoring of corrective action to ensure the practice will not recur- QA program in place** Audits will be completed and discussed weekly during Persons At Risk meeting. Any issues identified will be immediately addressed with staff. Findings will be discussed in quarterly QA meetings. Alzheimer's Care Unit Director/designee will be responsible to ongoing compliance. **Completion Date: February 26, 2011**	

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F 329	Continued From page 46 The clinical record for Resident #13 was reviewed on 01/24/11 at 11:45 A.M. The resident had been admitted to the facility on 04/22/10 from an inpatient psychiatric facility with diagnosis, including but not limited to, Dementia with psychosis, Depression, and Anxiety. The resident's current medication regimen included Depakote 125 mg three times a day for "psychosis" and Fazaclo 25 mg at bedtime for "psychosis." Review of the behavior monitoring records for January for Resident #13 indicated the resident's diagnosis of "psychosis" was noted at the bottom of the form and "wandering" was supposed to be monitored. Interview with the Administrator, on 01/26/11 at 2:00 p.m. indicated the resident was receiving both Depakote and Fazaclo for "anxiety" but since the resident had not shown any anxiety, they were only monitoring the resident for "wandering." Review of the January 2011 behavior monitoring record indicated there were no episodes of "wandering" documented even though the resident was observed to to have wandered up and down the hallway of the AAU unit on 01/24/11 and 01/25/11. When queried as to why the resident needed psychotropic medications for "wandering" and/or "anxiety" the administrator indicated the psychiatrist had documented the medications were necessary and were contra indicated for a dose reduction. Interview with the unit manager on 01/26/11, during observation of the noon meal, indicated she had gotten clarification from the psychiatrist and the resident was receiving the medication for a history of violent behavior and she would be	F 329		

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F 329	Continued From page 47 changing the behavior monitoring forms to address the appropriate behaviors. 3.1-48(a)(3)	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding	F 334	**F 334 Influenza and Pneumococcal Immunizations** The intent of the facility is to ensure that residents receive influenza vaccinations and receive timely pneumococcal vaccinations. **Corrective Action for Affected Residents** Res #54, #27 and #16 have received immunizations. **Identification and corrective action taken for other residents potentially affected** 100% audit of flu vaccinations completed on 2/11/2011 with no other concerns identifed. 100% audit of pneumococcal vaccinations completed on 2/11/2011 with 3 residents indentified as needing vaccination.	

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F 334	Continued From page 48 the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 resident [Resident #54] received an influenza vaccination, 1 resident [Resident #27] received a timely pneumococcal vaccination, and 1 resident [Resident #16] did not receive two influenza vaccinations, in sample of	F 334	**Measures/Systemic changes to ensure that the deficient practice does not recur** Inservice with Medical Records Coordinator to ensure vaccination orders and consents are obtained on new admissions and all Nursing Managers inserviced on immunization policy on February 16, 2011. New admission vaccination audit will be completed within 48 hours after admission and Nursing Managers will review Influenza protocol annually. **Monitoring of corrective action to ensure the practice will not recur- QA program in place** Audits will be completed and discussed weekly during Persons At Risk meeting. Any issues identified will be immediately addressed with staff. Findings will be discussed in quarterly QA meetings. DON/Designee will be responsible for ongoing compliance **Completion Date: February 26, 2011**	

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F 334	Continued From page 49 15 residents reviewed for immunizations in a total sample of 15 residents. Findings include: 1. The record for Resident #54 was reviewed on 1/25/11 at 10:30 a.m. An immunization form for Resident #54 indicated the resident's representative had signed a consent for the influenza vaccination on 8/24/2005. The consent indicated "I hereby request that the influenza vaccine be given on an annual basis as per facility policy...." An "Immunization Record" form for Resident #54 indicated the resident had last been administered the influenza vaccination on 10/22/2008. A Physician Order monthly re-cap for January. 2011 indicated "May have annual flu vaccine." The monthly re-cap indicated the standing order for the annual influenza vaccination had a start date of 10/9/2009. The facility Director of Nursing [DN] was interviewed on 1/25/11 at 4:15 p.m. During the interview, the DN indicated the facility had administered the influenza vaccine to residents in September and October, but Resident #54 had not yet received the influenza vaccination. The DN indicated Resident #54 would receive the vaccine by the next day. 2. The record for Resident #27 was reviewed on 1/26/11 at 9:00 a.m. Admission orders for Resident #27, dated 7/12/10, indicated "May have annual flu vaccine &	F 334		

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F 334	Continued From page 50 pneumo vac [sic] c [with] consent." A form titled "Immunization: Consent or Refusal" was signed by the resident's representative on 7/12/10 and indicated consent was given for the administration of the pneumococcal vaccine at that time. A physician's order, dated 9/14/10, indicated "give pneumonia vaccine." The Medication Administration Record [MAR] for Resident #27 for September 2010 indicated the pneumococcal vaccine was administered to the resident on 9/25/10. There was no indication in Resident #27's record of the administration of the pneumococcal vaccine until 9/25/10. 3. The record for Resident #16 was reviewed on 1/27/11 at 10:00 a.m. A form titled "Immunization: Consent or Refusal" was signed by the resident's representative on 8/17/10 and indicated consent was given to administer the influenza vaccine to Resident #16 at that time. A physician's order, dated 12/28/10, indicated "may give flu vaccine c [with] consent." The Medication Administration Record for Resident #16 for 12/2010 indicated influenza vaccine was administered on 12/29/10. There was no documentation on Resident #16's immunization record to indicate the influenza vaccination had been administered on 12/29/10.	F 334		

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F 334	Continued From page 51 A physician's order, dated 1/26/11, indicated "give flu vaccine." The MAR for Resident #16 for January 2011 indicated the resident received an additional dose of the influenza vaccine on 1/26/11. The facility DN was interviewed on 1/27/11 at 2:05 p.m. The DN indicated she conducted periodic audits for immunizations, but accurately tracking immunizations was a problem, as the nursing staff were not consistently documenting immunizations on the immunization forms. A facility policy titled "Influenza and Pneumococcal Vaccination", dated 9/2002, indicated residents were to receive the influenza vaccine "Annually... unless medically contraindicated or the resident has already received the influenza vaccine during the appropriate time period." The policy also indicated "Pneumococcal Vaccine will be made available at any time to residents as ordered by the physician." The policy further indicated "Record all influenza and pneumococcal vaccines administered on the Immunization Record and maintain in the medical record."	F 334		
F 369 SS=D	3.1-13(a) 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by:	F 369	**F 369 Assistive Devices- Eating Equipment/Utensils** The intent of the facility is to provide the adaptive dining equipment of a plate guard for residents with adaptive dining equipment. **Corrective Action for Affected Residents** Res #58 evaluated for need of plate guard **Identification and corrective action taken for other residents potentially affected**	

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F 369	Continued From page 52 Based on observation, interview and record review the facility failed to provide the adaptive dining equipment of a plate guard as ordered for 1 of 3 residents (Resident #58) with adaptive dining equipment in a total sample of 15. Findings include: Review of the clinical record of Resident #58 on 1/26/11 at 9:50 a.m., indicated the following: diagnoses included, but were not limited to, cerebrovascular accident. A current physician's order for Resident #58, dated 1/4/11, indicated she was to have a plate guard at meals. A Speech Therapy Treatment Encounter Note for Resident #58, dated 9/2/10, indicated a patient/caregiver instruction of "...education with staff and dietary on need for plate guard at meals to increase self feeding and decrease behaviors/frustration...." A Nutritional Re-evaluation Note for Resident #58, dated 9/13/10, indicated a plate guard was added at meals on 9/2/10. A facility Care Plan for Resident #58, with a revision date of 11/10/10, indicated a problem of cerebrovascular accident with right sided hemiparesis (paralysis). Approaches to the problem included, but were not limited to, plate guard at meals. A current dining tray card for Resident #58, provided by the facility Consulting Dietitian on 1/26/11 at 3:20 p.m., indicated she was to receive the adaptive equipment of a plate guard.	F 369	All other residents evaluated for need of plate guards and no concerns identified. **Measures/Systemic changes to ensure that the deficient practice does not recur** Dietary Manager will audit dietary trays to ensure plate guards are provided on resident trays. Audit will be performed 3 times per week. **Monitoring of corrective action to ensure the practice will not recur- QA program in place** Audits will be completed and discussed weekly during Patients At Risk meeting. Any issues identified will be immediately addressed with staff. Findings will be discussed in quarterly QA meetings. Dietary Manager/designee will be responsible for ongoing compliance **Completion Date: February 26, 2011**	

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F 369	Continued From page 53 During an observation of the lunch meal on 1/24/11 at 12:20 p.m., Resident #58 was observed to receive her meal tray. There was no plate guard provided. During an observation of the lunch meal on 1/25/11 at 12:20 p.m., Resident #58 was observed to receive her meal tray. There was no plate guard provided. During an observation of the evening meal on 1/25/11 at 5:50 p.m., Resident #58 was observed to receive her meal tray. There was no plate guard provided. A policy on following physician orders was requested during the exit conference on 1/26/11 at 4:10 p.m. The Administrator was interviewed on 1/27/11 at 9:00 a.m. During the interview she indicated the facility did not have a policy on following physician orders. She also indicated it was to be understood physician orders were to be followed. The Dietary Manager was interview on 1/27/11 at 9:50 a.m. During the interview he indicated the dietary department was responsible for putting adaptive dining equipment on meal trays.	F 369		
F 371 SS=E	3.1-21(h) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	**F 371 Food Procure, store/prepare/serve- sanitary** The intent of the facility is to ensure temperatures of food are taken at the time of service and clean plates, silverware, glasses, cups and serving utensils are transported to minimize the possibility of contamination **Corrective Action for Affected Residents**	

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F 371	Continued From page 54 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure temperatures of food were taken at the time of service and clean plates, silverware, glasses, cups, and serving utensils were transported to minimize the possibility of contamination in 1 of 3 dining rooms observed, potentially affecting 26 of 26 residents (including Residents #32, #76, #77, #78, and #79) residing on the second floor. Findings include: During confidential interviews with residents #76, #77, #78, and #79 on 1/25/11, the residents indicated hot food served in the large dining room on the second floor was sometimes served cold. During an observation of the evening meal in the large dining room on the second floor on 1/25/11 at 5:45 p.m., nineteen residents were observed seated at tables. The food was delivered by kitchen staff from the basement kitchen via an elevator at that time. The food was delivered on an open cart. The main entree was pizza. The pizza was already cut into individual slices, placed on platters covered with plastic wrap. The pizza sat on the cart for four minutes, until staff distributed the platters of pizza slices to the tables and the residents were served "family style".	F 371	Residents residing on Alzheimer's Care Unit are receiving covered utensils, glasses, plates and silverware. Temperatures will continue to be monitored for foods prior to placing on serving line in Dietary. Temperatures are now being monitored after delivery to Alzheimer's Units. **Identification and corrective action taken for other residents potentially affected** No other residents were identified. **Measures/Systemic changes to ensure that the deficient practice does not recur** Dietary staff educated on January 26, 2011 on transporting dining supplies and temperature taking. Dietary Manager will audit transportation of dining supplies being covered to ACU and temperature of foods after delivery to ACU. Audit will be conducted 3 times per week. **Monitoring of corrective action to ensure the practice will not recur- QA program in place**	

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F 371	Continued From page 55 No staff were observed to obtain the temperature of the pizza prior to serving it to the residents. Resident #32 was heard to indicate to his tablemates that the pizza was cold. Staff appeared not hear his comment. The lunch meal in the large dining room on the second floor was observed on 1/26/11. Nineteen residents were observed seated at tables. At 11:25 a.m., kitchen staff was observed to deliver an open cart of plates, glasses, coffee cups, silverware, and plastic serving spoons from the kitchen in the basement via the elevator. The cart was not covered or protected. At 12:05 p.m., kitchen staff was observed to deliver the food from the kitchen in the basement via the elevator. The food was delivered on an open cart. The food was in large serving bowls covered in plastic wrap. The meal included, but was not limited to, beef nuggets, mashed potatoes, and cooked carrots. The food sat on the cart for five minutes, until staff was observed to distribute the serving bowls to the tables and the residents were served "family style". Staff were not observed to obtain the temperature of the food prior to serving the residents. The Dietary Manager was interviewed on 1/27/11 at 12:18 p.m. During the interview he indicated clean dishes and serving utensils should be covered when transported from the kitchen. He also indicated food temperatures should be taken after the bulk food was delivered from the kitchen to the second floor dining room prior to the family style dining service.	F 371	Audits will be completed and discussed daily if issues are identified in morning meeting. Any issues identified will be immediately addressed with staff. Findings will be discussed in quarterly QA meetings. Dietary Manager/designee will be responsible for ongoing compliance. **Completion Date: February 26, 2011**	

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F 371	Continued From page 56 A facility policy titled "Monitoring Food Temperatures for Food Service", dated 2010, indicated "Food temperatures will be taken and recorded for all hot and cold foods prior to placing them on the serving line." The policy also indicated "All hot foods will be kept in covered steam table pans on the steam table." 3.1-21(a)(2) 3.1-21(i)(3)	F 371		